

063120 AUG 19 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| FOR STATE REGISTRAR   |  |   |  |   | REG. NO. 24439   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEVEN ALBERT ANDERSON, III</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Aug. 13, 1987</b> |   |  | 2b. HOUR<br><b>7:10 p.m.</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 4, 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Somerset</b> MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chance</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MD Route 363 (Home)</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Proprietor</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Marine Hardware</b>  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Somerset</b>  |  | 13c. CITY OR TOWN<br><b>Chance</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>P.O. Box 154 / 21816</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Leven Albert Anderson</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Georgia May Goslee</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-0939</b>  |  | 17. INFORMANT ADDRESS<br><b>Alice A. Ellison - same as 13 above</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Colon Cancer.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Paul R. Fleury</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>8/14/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul R. Fleury, M.D.</b>  |  | 22e. ADDRESS<br><b>Cedar &amp; 10th Sts. / Pocomoke City, MD 21851</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/15/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Chance - Somerset - MD</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bradshaw &amp; Sons / Crisfield, MD 21817</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 18 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

063150 JMS 1287

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24440

FOR  
STATE  
REGISTRAR

1. DECEASED NAME

FIRST  
WILLIAMMIDDLE  
H.LAST  
BYRD, JR.2a. DATE OF DEATH MONTH DAY YEAR  
August 19, 19872b. HOUR  
6:15 a.m.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
Feb. 13, 1916

6. AGE (IN YEARS (LAST BIRTHDAY))

71

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Somerset County

MD

10. CITY OR TOWN OF DEATH

Marion

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Home- Rt. 1 - Powell Rd.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Serviceman

12b. KIND OF BUSINESS OR INDUSTRY

Electrical

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Somerset

13c. CITY OR TOWN

Marion

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

Rt. 1-Powell Rd. (21838)

14. FATHER'S NAME

FIRST  
William

MIDDLE

H.

LAST

Byrd, Sr.

15. MOTHER'S MAIDEN NAME

FIRST  
Elizabeth

MIDDLE

Owens

LAST

Owens

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)

none

16c. SOCIAL SECURITY NO

215-10-7297

17. INFORMANT

Bessie M. Byrd

ADDRESS

P. O. Box 263  
Marion Station, Md. 2183818. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

mesothelioma Pleura  
Rt

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

monthly

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/28/87 to 7/28/87, that (I) (we) lost  
saw the deceased alive or above, (I) (we) (did) (did not) view the body after death. and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

Dr. M. Barhan

DEGREE

M.D.

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

8/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. M. Barhan

22e. ADDRESS

Rt. 1-Md. Route # 413- Crisfield, Md. 21817

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

8/21/87

23c. NAME OF CEMETERY OR CREMATORY

Asbury Cemetery

23d. LOCATION

CITY OR TOWN

Crisfield, Somerset Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Bradshaw &amp; Sons

ADDRESS

Crisfield, Md. 21817

25. DATE OF REGISTRATION 25b. REGISTRAR'S SIGNATURE

AUG 24 1987

[Signature]

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the funeral director. Page 4 may be filed with the funeral director. Page 5 should be filed with the funeral director. Page 6 should be filed with the funeral director. Page 7 should be filed with the funeral director. Page 8 should be filed with the funeral director. Page 9 should be filed with the funeral director. Page 10 should be filed with the funeral director. Page 11 should be filed with the funeral director. Page 12 should be filed with the funeral director. Page 13 should be filed with the funeral director. Page 14 should be filed with the funeral director. Page 15 should be filed with the funeral director. Page 16 should be filed with the funeral director. Page 17 should be filed with the funeral director. Page 18 should be filed with the funeral director. Page 19 should be filed with the funeral director. Page 20 should be filed with the funeral director. Page 21 should be filed with the funeral director. Page 22 should be filed with the funeral director. Page 23 should be filed with the funeral director. Page 24 should be filed with the funeral director. Page 25 should be filed with the funeral director. Page 26 should be filed with the funeral director. Page 27 should be filed with the funeral director. Page 28 should be filed with the funeral director. Page 29 should be filed with the funeral director. Page 30 should be filed with the funeral director. Page 31 should be filed with the funeral director. Page 32 should be filed with the funeral director. Page 33 should be filed with the funeral director. Page 34 should be filed with the funeral director. Page 35 should be filed with the funeral director. Page 36 should be filed with the funeral director. Page 37 should be filed with the funeral director. Page 38 should be filed with the funeral director. Page 39 should be filed with the funeral director. Page 40 should be filed with the funeral director. Page 41 should be filed with the funeral director. Page 42 should be filed with the funeral director. Page 43 should be filed with the funeral director. Page 44 should be filed with the funeral director. Page 45 should be filed with the funeral director. Page 46 should be filed with the funeral director. Page 47 should be filed with the funeral director. Page 48 should be filed with the funeral director. Page 49 should be filed with the funeral director. Page 50 should be filed with the funeral director. Page 51 should be filed with the funeral director. Page 52 should be filed with the funeral director. Page 53 should be filed with the funeral director. Page 54 should be filed with the funeral director. Page 55 should be filed with the funeral director. Page 56 should be filed with the funeral director. 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Page 76 should be filed with the funeral director. Page 77 should be filed with the funeral director. Page 78 should be filed with the funeral director. Page 79 should be filed with the funeral director. Page 80 should be filed with the funeral director. Page 81 should be filed with the funeral director. Page 82 should be filed with the funeral director. Page 83 should be filed with the funeral director. Page 84 should be filed with the funeral director. Page 85 should be filed with the funeral director. Page 86 should be filed with the funeral director. Page 87 should be filed with the funeral director. Page 88 should be filed with the funeral director. Page 89 should be filed with the funeral director. Page 90 should be filed with the funeral director. Page 91 should be filed with the funeral director. Page 92 should be filed with the funeral director. Page 93 should be filed with the funeral director. Page 94 should be filed with the funeral director. Page 95 should be filed with the funeral director. Page 96 should be filed with the funeral director. Page 97 should be filed with the funeral director. Page 98 should be filed with the funeral director. Page 99 should be filed with the funeral director. Page 100 should be filed with the funeral director.

1. The first part of the report is a summary of the work done during the period covered by the report. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

2. The second part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

3. The third part of the report is a summary of the work done. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

4. The fourth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

5. The fifth part of the report is a summary of the work done. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

6. The sixth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

7. The seventh part of the report is a summary of the work done. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

8. The eighth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

9. The ninth part of the report is a summary of the work done. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

10. The tenth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

062740

AUG 14 1987  
FOR  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

2 4 4 4 1  
REG. NO.

|  |  |   |   |   |                                |  |  |
|--|--|---|---|---|--------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Arthur T. Cox, Jr.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8-9-87 |   | 2b. HOUR<br>10:30 <sup>a</sup> |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 6, 1928  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59<br>YRS MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Somerset MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Crisfield   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Edw. W. McCready Mem. Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pre-Cooked Foods  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Somerset   |   | 13c. CITY OR TOWN<br>Crisfield  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur T. Cox  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Pusey  |   | 16. STREET ADDRESS / ZIP CODE<br>43 Asbury Ave. / 21817   |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>Korean War<br>218-30-0901   |   | 17. INFORMANT<br>ADDRESS<br>Nancy P. Cox - same as 13 abcde   |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> |  |   |   |   |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |   |   |                                |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |  |
| 22a. I certify that (a) this hospital attended the deceased from <u>8/8/87</u> to <u>8/9/87</u> , that (b) we last saw the deceased on <u>8/8/87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If not, did not view the body after death).  |  |   |   |   |                                |  |  |
| 22b. SIGNATURE<br><u>James A. Stohy, MD</u>  |  | DEGREE  |   | 22c. DATE SIGNED<br><u>8/10/87</u>  |                                | 22d. MEDICAL STAFF<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. James Sterling  |  | 22f. ADDRESS<br>Main St., Crisfield, Md. 21817  |   |   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>8/12/87  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunnyridge Cemetery   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crisfield - Somerset - MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bradshaw & Sons, Main St., Crisfield, Md.  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 13 1987  |                                | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Twiss-Rodgers</u>   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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064630 SEP-30

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A LATER DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. THIS CERTIFICATE IS TO BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3, 9-10-1, 9-10-2, 9-10-3, 9-10-4, 9-10-5, 9-10-6, 9-10-7, 9-10-8, 9-10-9, 9-10-10, 9-10-11, 9-10-12, 9-10-13, 9-10-14, 9-10-15, 9-10-16, 9-10-17, 9-10-18, 9-10-19, 9-10-20, 9-10-21, 9-10-22, 9-10-23, 9-10-24, 9-10-25, 9-10-26, 9-10-27, 9-10-28, 9-10-29, 9-10-30, 9-10-31, 9-10-32, 9-10-33, 9-10-34, 9-10-35, 9-10-36, 9-10-37, 9-10-38, 9-10-39, 9-10-40, 9-10-41, 9-10-42, 9-10-43, 9-10-44, 9-10-45, 9-10-46, 9-10-47, 9-10-48, 9-10-49, 9-10-50, 9-10-51, 9-10-52, 9-10-53, 9-10-54, 9-10-55, 9-10-56, 9-10-57, 9-10-58, 9-10-59, 9-10-60, 9-10-61, 9-10-62, 9-10-63, 9-10-64, 9-10-65, 9-10-66, 9-10-67, 9-10-68, 9-10-69, 9-10-70, 9-10-71, 9-10-72, 9-10-73, 9-10-74, 9-10-75, 9-10-76, 9-10-77, 9-10-78, 9-10-79, 9-10-80, 9-10-81, 9-10-82, 9-10-83, 9-10-84, 9-10-85, 9-10-86, 9-10-87, 9-10-88, 9-10-89, 9-10-90, 9-10-91, 9-10-92, 9-10-93, 9-10-94, 9-10-95, 9-10-96, 9-10-97, 9-10-98, 9-10-99, 9-10-100.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24442

|   |  |                           |  |  |  |  |  |                         |  |                                  |  |
|---|--|---------------------------|--|--|--|--|--|-------------------------|--|----------------------------------|--|
| 1- STATE REGISTRAR                              |  | 2a. DATE KNOWN OF DEATH   |  | 2b. DATE KNOWN OF DEATH                                  |  | 2c. DATE KNOWN OF DEATH                                      |  | 2d. DATE KNOWN OF DEATH |  | 2e. DATE KNOWN OF DEATH          |  |
| 3- DECEASED NAME (LAST, FIRST, MIDDLE OR PRINT) |  | 4- RACE                   |  | 5- DATE OF BIRTH   |  | 6- AGE (IN YEARS)  |  | 7- DATE KNOWN OF DEATH  |  | 8- DATE KNOWN OF DEATH           |  |
| Jeanette M. Hickman                             |  | White                     |  | April 5, 1918  |  | 69 YRS.  |  | 8/ 27/ 19 87            |  | 8/ 27/ 19 87                     |  |
| 9- BIRTHPLACE (STATE OR FOREIGN COUNTRY)        |  | 10- CITY OR TOWN OF DEATH |  | 11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 13- STREET ADDRESS      |  | 14- KIND OF BUSINESS OR INDUSTRY |  |
| Maryland  |  | Crisfield                 |  | 105 Cove St.   |  | Seamstress   |  | 105 Cove St. / 21817    |  | Clothing Mfg.                    |  |
| 15- FATHER'S NAME                               |  | 16- MOTHER'S MAIDEN NAME  |  | 17- INFORMANT  |  | 18- SOCIAL SECURITY NO.                                      |  | 19- DATE OF OPERATION   |  | 20- AUTOPSY?                     |  |
| Charles J. Moore                                |  | Martha E. Blades          |  | Linda J. Sendall - Crisfield, MD 21817                   |  | 213-14-7094  |  | 21- DATE OF OPERATION   |  | 22- AUTOPSY?                     |  |
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| 405- DATE OF OPERATION                          |  | 406- AUTOPSY?             |  | 407- DATE OF OPERATION                                   |  | 408- AUTOPSY?  |  | 409- DATE OF OPERATION  |  | 410- AUTOPSY?                    |  |
| 409- DATE OF OPERATION                          |  | 410- AUTOPSY?             |  | 411- DATE OF OPERATION                                   |  | 412- AUTOPSY?  |  | 413- DATE OF OPERATION  |  | 414- AUTOPSY?                    |  |
| 413- DATE OF OPERATION                          |  | 414- AUTOPSY?             |  | 415- DATE OF OPERATION                                   |  | 416- AUTOPSY?  |  | 417- DATE OF OPERATION  |  | 418- AUTOPSY?                    |  |
| 417- DATE OF OPERATION                          |  | 418- AUTOPSY?             |  | 419- DATE OF OPERATION                                   |  | 420- AUTOPSY?  |  | 421- DATE OF OPERATION  |  | 422- AUTOPSY?                    |  |
| 421- DATE OF OPERATION                          |  | 422- AUTOPSY?             |  | 423- DATE OF OPERATION                                   |  |  |  |                         |  |                                  |  |



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062582 AUG 13 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS AND CERTAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 24443

|  |   |   |   |   |                                     |
|--|---|---|---|---|-------------------------------------|
| 1- STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH                                     |   | 2b. HOUR  |                                     |
| DECEASED NAME (TYPE OR PRINT)  |   | FIRST MIDDLE LAST   |   | MONTH DAY YEAR  |                                     |
| ROWLAND  |   | M. HILL   |   | 8-9-87 19 4:30P   |                                     |
| 3 SEX  | 4 RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS.                    |
| Male   | White   | 10 24 1936  | 50 YRS.   | MONTHS DAYS HOURS MIN.  |                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH |
| Maryland   | U.S.  |   |   |   | Somerset County MD                  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Pr. Anne   | Racoon Pt. end of Revells Neck Rd. Manokin River  |   | Const. Worker   |   |                                     |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |                                     |
| Maryland   | Somerset  | Pr. Anne  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | Antioch Avenue 21853  |                                     |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME                                    |   |   |                                     |
| FIRST MIDDLE LAST  |   | FIRST MIDDLE LAST   |   |   |                                     |
| James Marshall Hill  |   | Anna Lee Webster  |   |   |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.                                    |   | 17. INFORMANT   |                                     |
| No   |   | 215-36-1080   |   | Lillian Mezick, Fruitland, Md.  |                                     |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |   |   |   |                                     |
| PART I DEATH WAS CAUSED BY:  |   |   |   |   |                                     |
| IMMEDIATE CAUSE (a) <u>Drowning</u>  |   |   |   |   |                                     |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |   |                                     |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |   |   |   |   |                                     |
| (b) <u></u>  |   |   |   |   |                                     |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |   |                                     |
| (c) <u></u>  |   |   |   |   |                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |   |   |   |   |                                     |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   | 20. AUTOPSY?  |                                     |
|  |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                     |
|  |   | 4:30PM 8-9-87 19  |   | subject drowned   |                                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION   |                                     |
|  |   | river   |   | Racoon Pt. end of Revells Neck Rd. Manokin River Somerset Co., Maryland       |                                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |   |   |   |                                     |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)   |   | DATE SIGNED   |                                     |
| <i>Margareta A. Korell</i>   |   | M.D. Assistant MEDICAL EXAMINER                             |   | 8-10-87   |                                     |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS   |   |   |                                     |
| Margarita A. Korell, M.D.  |   | 111 Penn Street   |   |   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                          | 23d. LOCATION   |   |                                     |
| Burial   | 08/12/87  | Beechwood   | Pr. Anne, Somerset Md   |   |                                     |
| 24. FUNERAL DIRECTOR   |   | NAME  |   | ADDRESS   |                                     |
| James L. Hinman, Pr. Anne, Md.   |   | 21853   |   |   |                                     |

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

AUG 11 1987

062282 AUG 13 67

Info with to 24 1967

Mr. Anne

Mr. Anne

Mr. Anne

Mr. Anne

24-36-1080



NOTICE

15

Mr. Anne

Mr. Anne

(VR A15 A) (5)

001330 AUG-2-87

AUG 02 1987

061932 AUG - 7-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24445

|  |  |                  |                   |   |  |  |  |   |                |                          |  |   |  |          |  |    |  |
|--|--|------------------|-------------------|---|--|--|--|---|----------------|--------------------------|--|---|--|----------|--|----|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST MIDDLE LAST |   |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTI-<br>MATED <input type="checkbox"/> |  |   | MONTH DAY YEAR |                          |  | 2b. HOUR  |  |          |  |    |  |
| Dennis   |  |                  | Washington        |   |  | Jones, III   |  |   | 8/ 3/ 19 87    |                          |  | M   |  |          |  |    |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6-7-86  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>1 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |                | 7c. DATE PRONOUNCED DEAD |  | MONTH DAY YEAR  |  | 2d. HOUR |  |    |  |
|  |  |                  |                   |   |  |  |  |   |                | 8/ 3/ 19 87              |  | 8:45  |  | a m      |  |    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NY  |  |                  |                   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Somerset County                             |  |          |  | MD |  |
| 10. CITY OR TOWN OF DEATH<br>Princess Anne   |  |                  |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Rt. 13 North Princess Ann |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unemployed   |                |                          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |    |  |
| 13a. STATE<br>NY   |  |                  |                   | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN<br>Brooklyn   |                |                          |  | 13d. STREET ADDRESS<br>112-38 205th St.   |  |          |  |    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dennis Jones Jr.   |  |                  |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lynne McBane   |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |                |                          |  | 16b. SOCIAL SECURITY NO.<br>-----   |  |          |  |    |  |
| 17. INFORMANT<br>ADDRESS<br>Gladys McBane 1544 Bergen St.  |  |                  |                   |   |  |  |  |   |                |                          |  |   |  |          |  |    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Injuries<br>8/5/1<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)  |  |                  |                   |   |  |  |  |   |                |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |          |  |    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                   |   |  |  |  |   |                |                          |  |   |  |          |  |    |  |
| 19a. DATE OF OPERATION   |  |                  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                |                          |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>7:45 AM 8/ 3/ 1987   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject passenger in auto/fixed object impact                              |                |                          |  |   |  |          |  |    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                  |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Rt. 13, north Princess Ann, Somerset Co., Md.  |                |                          |  |   |  |          |  |    |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                   |   |  |  |  |   |                |                          |  |   |  |          |  |    |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth  |  |                  |                   | TITLE (SPECIFY)<br>Assistant  |  |  |  | DATE SIGNED<br>8/3/87   |                |                          |  |   |  |          |  |    |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  |                  |                   | ADDRESS<br>111 Penn St.   |  |  |  |   |                |                          |  |   |  |          |  |    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |                   | 23b. DATE<br>8-7-87   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Cem.  |                |                          |  | 23d. LOCATION<br>CITY OR TOWN<br>Brooklyn N.Y.                                      |  |          |  |    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Carlton C. Douglas   |  |                  |                   | ADDRESS<br>1701 McCullough St.  |  |  |  | 25. DATE REC'D BY REGISTRAR<br>AUG 05 1987  |                |                          |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Gordon-Randall                                  |  |          |  |    |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

99999999  
07/84  
BP  
DHMH-17  
(VR A15 ME (5))

061232 WGS-281



200% COTTON FIBER

WINTER

WGS-281



061931 AUG -7 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 4 4 4 0

|  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>Lynn   |  |  | MIDDLE<br>M.   |  |  | LAST<br>Jones  |  |  | 2b. DATE, KNOWN OF DEATH ESTIMATED<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  |  | 2d. HOUR  |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>Black  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 18 62  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>25 YRS  |  |  | IF UNDER 1 YR.<br>MONTHS DAYS  |  |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Somerset County                              |  |  | 2c. DATE PRONOUNCED DEAD<br>8/ 3/ 1987   |  |  | 2d. HOUR<br>8:45  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Princess Anne   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Rt. 13 North Princess Ann |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teller  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>banking   |  |  |  |  |  |   |  |  |
| 13a. STATE<br>NY   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br>Brooklyn  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>112-38 205th St.  |  |  |   |  |  |
| 14. FATHER'S NAME<br>John  |  |  | MIDDLE<br>McBane  |  |  | LAST<br>Gladys   |  |  | 15. MOTHER'S MAIDEN NAME<br>Gladys   |  |  | MIDDLE<br>Bethea   |  |  | LAST  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br>Gladys McBane   |  |  | ADDRESS<br>1544 Bergen St.   |  |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Injuries<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>7:45 AM 8/ 3/ 1987   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>subject passenger in auto/fixed object impact                   |  |  |  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Rt. 13, north Princess Ann, Somerset Co., Md.   |  |  |  |  |  |  |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:<br>Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.  |  |  | TITLE (SPECIFY)<br>Assistant  |  |  | M.D. MEDICAL EXAMINER  |  |  | DATE SIGNED<br>8/4/87  |  |  |  |  |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |  | ADDRESS<br>111 Penn St.   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>8-7-87   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn NY.                           |  |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Carlton C. Douglas   |  |  | ADDRESS<br>1701 McCulloch St.   |  |  | 25a. DATE REC'D BY REGISTRAR<br>AUG 05 1987  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Dandora-Kandath                                  |  |  |  |  |  |   |  |  |

DIVISION OF VITAL RECORDS, 301 W. PESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH -  
(VR A15 ME (5))



081331 WCC-285

20% COTTON LIPES

WILSON

063487 AUG 24 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24447

REG. NO.

1- FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

AGNES

J.

LAZZARA

2a. DATE OF DEATH MONTH DAY YEAR  
8-19-87  
2b. HOUR  
440 A M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
02 18 1911

6. AGE (IN YEARS (LAST BIRTHDAY))

76

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 74 HRS

HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Tampa, Florida

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Somerset

MD

10. CITY OR TOWN OF DEATH

Princess Anne

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Manokin Manor Nursing Home

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Somerset

13c. CITY OR TOWN

Princess Anne

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

Manokin Manor 21853

14. FATHER'S NAME

Andrew

MIDDLE

LAST

Gramling

15. MOTHER'S MAIDEN NAME

Bessie

FIRST

MIDDLE

LAST

Everetson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

261-22-7464

17. INFORMANT

Elizabeth Fusaro

ADDRESS  
216-A Barry Rd  
West Point, N.Y. 1099618. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Carcinoma / Ascaris

DUE TO, OR AS A CONSEQUENCE OF

(c)

Portal Hypertension

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Senile Dementia - Alzheimer Type

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 86 to 8-19 87 that (I) (we) last saw the deceased alive on 8-15 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

C Stegman

DEGREE

MS

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

8-19-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Charles Stegman, M.D.

22e. ADDRESS

Princess Anne, Maryland 21853

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b. DATE

8-20-1987

23c. NAME OF CEMETERY OR CREMATORY

Delmarva Crematory

23d. LOCATION  
CITY OR TOWN

Lewes

COUNTY

Sussex

STATE

Delaware

24. FUNERAL DIRECTOR

BAKER AND BOUNDS

SALISBURY, MARYLAND

25a. DATE REC'D. BY REGISTRAR

AUG 21 1987

25b. REGISTRAR'S SIGNATURE

John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove earlier papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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63640 AUG 25 87

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24448  
REG. NO.

|  |  |  |  |   |   |  |   |  |                                      |   |  |
|--|--|--|--|---|---|--|---|--|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Robert H. McDorman   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Aug. 16. 1987                   |   | 2b. HOUR<br>4:30 M                                |  |   |  |                                      |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 22, 1897   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89<br>YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                      | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Somerset MD                            |   |  |                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>Westover  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Route 1 |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Somerset  |   | 13c. CITY OR TOWN<br>Westover                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Route 1 21871 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alexander Wright McDorman  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Mary Dorsey  |   |  |   |  |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-34-7595   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Joan Farrow, Salisbury, Md.  |   |  |   |  |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>arterio sclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)           |  |  |  |   |   |  |   |  |                                      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><i>diabetes</i>  |  |  |  |   |   |  |   |  |                                      |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |                                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |                                      |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-26</i> , 19 <i>87</i> , to <i>3-26</i> , 19 <i>87</i> , that (I) (we) lost<br>saw the deceased alive on <i>3-26</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |                                      |   |  |
| 22b. SIGNATURE<br><i>C. Heeger</i>   |  |  |  |   |   | DEGREE<br><i>Ms</i>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      | 22c. DATE SIGNED<br><i>8-18-87</i>                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Charles D. Stegman</i>   |  |  |  |   |   | 22e. ADDRESS   |   |  |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>8/19/87   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Andrews |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Princess Anne, Somerset, Md.   |                                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>James J. Henman Jr.</i>   |  |  |  |   |   | ADDRESS<br>Princess Anne, Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 24 1987   |                                      | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i> |  |

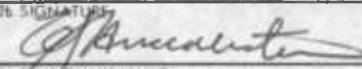



062387 AUG 11 87

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

24449  
REG. NO.

|   |   |   |  |   |   |  |
|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(IF OCCURRING)<br>FIRST MIDDLE LAST<br><b>EDMUND J. NEALE</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8/4/87</b>             |   | 2b. HOUR<br><b>10:20 PM</b>   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 05 15</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                    |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Somerset</b> MD.                         |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crisfield</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edward W. McCready Mem. Hosp.</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waterman</b> |   |  |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY<br><b>Somerset</b>                                   | 13c. CITY OR TOWN<br><b>Crisfield</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edmund L. Neale</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Elizabeth Rausch</b>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>097-03-7523</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Winifred H. Neale Same as 13 a,b,c,d,e</b>           |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Invasive Bladder Ca.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/14/87</b> 19____ to <b>8/4/87</b> 19____, that (I) (we) last saw the deceased alive on <b>8/4/87</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |   |  |
| 22b. SIGNATURE<br>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>8/04/87</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. J. Huddleston, M.D.</b>  |   | 22e. ADDRESS<br><b>Crisfield, MD 21817</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>8/5/87</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Salisbury Crematory</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Salisbury Wicomico Md.</b>                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bradshaw &amp; Sons</b>  |   | ADDRESS<br><b>Crisfield, Md. 21817</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 10 1987</b>                                 |   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br>   |  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24450  
REG NO

|   |   |  |   |   |                                     |
|---|---|--|---|---|-------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 20. DATE OF DEATH  |   | 2b. HOUR  |                                     |
| FIRST MIDDLE LAST<br><b>Matthew M. Pepper</b>   |   | MONTH DAY YEAR<br><b>Aug. 5. 1987</b>  |   | <b>2: A.M.</b>  |                                     |
| 3 SEX   | 4 RACE  | 5. DATE OF BIRTH   |   | 6. AGE  |                                     |
| <b>Male</b>   | <b>Caucasian</b>  | MONTH DAY YEAR<br><b>Feb. 29, 1928</b>   |   | (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS   |                                     |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH   |                                     |
| <b>New Jersey</b>   | <b>U.S.</b>   |  |   | <b>Somerset</b> MD  |                                     |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY    |
| <b>Pr. Anne</b>   | <b>Route 3, Box 76</b>  |  | <b>Letter Carrier</b>   |   | <b>USPS</b>                         |
| 13a STATE   |   | 13b COUNTY   | 13c CITY OR TOWN  | 13d INSIDE CITY LIMITS?   | 13e STREET ADDRESS / ZIP CODE       |
| <b>Maryland</b>   |   | <b>Somerset</b>  | <b>Pr. Anne</b>   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | <b>Route 3, Box 76</b> <b>21853</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   | 16a. SOCIAL SECURITY NO.  |                                     |
| <b>Kenneth</b> <b>Pepper</b>  |   | <b>Gertrude</b> <b>Arnoul</b>  |   | <b>139-20-4090</b>  |                                     |
| 16b. DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 17 INFORMANT   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Presumed myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Diabetes</u> |                                     |
| <b>No</b>   |   | <b>Elizabeth Pepper, Pr. Anne, Md.</b>   |   | <b>Route 3, Box 76</b><br><b>21853</b>  |                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c   |   |  |   |   |                                     |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?  |                                     |
|   |   |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                     |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                     |
|   |   |  |   |   |                                     |
| 22a. certify that (I) (this hospital) attended the deceased from <u>6-3</u> 19 <u>87</u> , to <u>10-11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6-3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |   |                                     |
| 22b. SIGNATURE  |   | DEGREE   |   | 22c. DATE SIGNED  |                                     |
| <u>C. Hagan</u>   |   | <u>MD</u>  |   | <b>8-5-87</b>   |                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS   |   |   |                                     |
|   |   |  |   |   |                                     |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b DATE   | 23c NAME OF CEMETERY OR CREMATORY                               | 23d LOCATION<br>CITY OR TOWN COUNTY STATE   |                                     |
| <b>Burial</b>   |   | <b>8/8/87</b>  | <b>Grace Episcopal</b>  | <b>Mt. Vernon Somerset Md</b>   |                                     |
| 24 FUNERAL DIRECTOR<br>NAME   |   | 25a DATE REC'D. BY REGISTRAR   |   | 25b REGISTRAR'S SIGNATURE   |                                     |
| <b>James L. Hinman, Pr. Anne, Md.</b>   |   | <b>21853</b>   |   | <b>AUG 11 1987</b><br><i>Julia Davidson-Kendall</i>   |                                     |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

062283 AUG 13 67

2:4

Aug. 1, 1967

Letter

Letter

John

Unopened

Feb. 20, 1967

20

Unopened

"B."

John

Mr. Anne

Route 2, Box 76

Letter dated 1967

Married

Unopened

Route 2, Box 76

Married

Unopened

Unopened

Unopened

Route 2, Box 76

1967-20-2000 Unopened, Pepper, Mr. Anne, No. 2122

Unopened

Unopened

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 4 4 5 1  
REG. NO.

FOR  
STATE  
REGISTRAR

|   |                         |   |   |   |   |  |   |  |
|---|-------------------------|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GRACE B. STERLING</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>Aug. 30, 1987</b> |   |   | 2b. DATE OF DEATH<br><input type="checkbox"/> MONTH DAY YEAR<br><b>Aug. 30, 1987</b> |   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 24, 1906</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>81</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>Aug. 30, 1987</b>                   | 7d. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug. 30, 1987</b>                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Somerset County</b> MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crisfield</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>McCready Memorial Hospital</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>                                |  |
| 13a. STATE<br><b>Maryland</b>   |                         |   | 13b. COUNTY<br><b>Somerset</b>  | 13c. CITY OR TOWN<br><b>Crisfield</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>30 W. Main St. (21817)</b>                                 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Purvis Bloxom</b>  |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma L. Parker</b>  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>212-10-5267</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>June Pusey Same as 13 a,b,c,d,e</b>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>Cardiac arrest</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Acute</b><br><b>Acute</b> |                         |   |   |   |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion     |                         |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>madhar d. Barhan</b>   |                         | TITLE (SPECIFY)<br><b>Deputy</b>  |   | MEDICAL EXAMINER  |   | DATE SIGNED<br><b>8/31/87</b>  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dr. M. Barhan</b>  |                         | ADDRESS<br><b>Rt. # 413 - Crisfield, Md. 21817</b>  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>9/1/87</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunnyridge Cemetery</b>                                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crisfield Somerset Md.</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bradshaw &amp; Sons</b>  |                         |   | ADDRESS<br><b>Crisfield, Md. 21817</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEPO2 1987</b>  |  |   |  |
|   |                         |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |   |   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALSO, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP  
DHMH - 17  
(VR A15 ME (5))  
15M/7/77

Handwritten notes and signatures at the top of the page, including a signature that appears to read "John W. ...".

Handwritten notes and signatures in the middle section of the page, including a signature that appears to read "John W. ...".

Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "John W. ...".

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24452  
REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELIZA WILSON  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>08 10 87                        |   |  | 2b. HOUR<br>12 00 N   |  |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08-17-1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Somerset MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dames, Qt.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manokin Manor Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Wife                  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Somerset   |  | 13c. CITY OR TOWN<br>Dames Qt   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>P.O. Box 39 21820  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alexander Johnson  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Roxbury  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>220-03-6081   |  | 17. INFORMANT<br>Pauline Drummond daughter  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Unknown</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA - multiple</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-sclerotic cerebro-vascular disease</u> |  |   |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>multi-infarct dementia</u>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> , 19 <u>85</u> , to <u>8-10</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>DEGREE<br>C. H. H. MS  |  |   |  |   |  | 22c. DATE SIGNED<br>8-11-87   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. H. H. MS   |  |   |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>08-15-87  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Macedonia   |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dames Qt. S Md   |  |   | 23e. DATE REC'D BY REGISTRAR<br>AUG 13 1987                            |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME James 3rd Church St. Princess Anne  |  |   |  |   |  |   |  |  |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |  |  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
|---|---------|--|--|--|--|-----------------------------------|--|---|--|--------------------------|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   |  | LAST                              |  | 2a. DATE KNOWN OF DEATH   |  |                          |  | 2b. HOUR  |  |  |  |  |  |
| Minnie Mae Zufall   |         |  |  |  |  |                                   |  | 8 16 1987   |  |                          |  | 2:50 PM   |  |  |  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD |  |   |  | 7d. HOUR                                     |  |  |  |
| Female  | White   | 7 MONTH 14 DAY 16 YEAR                                   |  | 71 YRS.  |  | MONTHS DAYS HOURS MIN.            |  |   |  | 8 16 1987                |  |   |  | 2:50 PM                                      |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED   |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                          |  |   |  |  |  |  |  |
| Somerset Co., PA  |         | US   |  | WIDOWED  |  | DIVORCED                          |  | Somerset Co. PA   |  |                          |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |                          |  |   |  |  |  |  |  |
| Cumberland, MD  |         | 311 Franklin St. Cumberland, MD                          |  | Housewife  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS   |  |                          |  |   |  |  |  |  |  |
| MD  |         | Allegany   |  | Cumberland   |  | YES                               |  | 311 Franklin St. 21502  |  |                          |  |   |  |  |  |  |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                 |  |  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| Jacob Martin Wyant  |         | Sadie Ellen Ware   |  |  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT  |  | ADDRESS                           |  |   |  |                          |  |   |  |  |  |  |  |
| no  |         | 213 40 3957  |  | James E. Zufall  |  | Cresaptown, MD                    |  |   |  |                          |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis secondary to colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Cancer</u><br>(b) <u>Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |  |  |  |  |                                   |  |   |  |                          |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |         |  |  |  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  |                                   |  |   |  |                          |  | 20. AUTOPSY?  |  |  |  |  |  |
|   |         |  |  |  |  |                                   |  |   |  |                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19           |  |                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |                          |  |   |  |  |  |  |  |
|   |         |  |  |  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)    |  |                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |                          |  |   |  |  |  |  |  |
|   |         |  |  |  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Francisco Reyes</u>   |         |  |  | TITLE (SPECIFY) <u>Deputy</u>                                  |  |                                   |  | DATE SIGNED <u>8-16-87</u>  |  |                          |  |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Francisco Reyes M.D.</u>   |         |  |  | ADDRESS <u>900 Seton Drive, Cumberland Md. 21502</u>           |  |                                   |  |   |  |                          |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |         |  |  | 23b. DATE <u>8-19-87</u>                                       |  |                                   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Memorial Park</u>              |  |                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cumberland, Allegany, MD</u> |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>James F. Scarpelli</u>   |         |  |  | ADDRESS <u>Cumberland, MD 21502</u>                            |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR <u>10021 1987</u>                               |  |                          |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                           |  |  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07:54  
25MBP  
DHMH - 17  
(VR A15 ME (15))

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MD. 21201



003813 W25893

Imperial Valley



WILFAM  
100% COTTON LIGER

Imperial Valley

Imperial Valley